TENNESSEE GENERAL ASSEMBLY
FISCAL REVIEW COMMITTEE

FISCAL NOTE

SB 401 - HB 561

March 17, 2013

SUMMARY OF BILL: Requires the state to implement provider data verification and provider screening technology solutions into the claims processing workflow to check current healthcare billing and provider rendering data against a continually maintained provider information database for purposes of automating review and identifying and preventing inappropriate payments to deceased providers, sanctioned providers, inactive providers, and confirmed wrong addresses. The state is required to implement state-of-the-art predictive modeling and analytics techniques in a pre-payment position within the healthcare claim workflow to prevent fraud in the TennCare program and CoverKids (the state Children's Health Insurance Program (CHIP)). The state is required to ensure that the savings achieved through the technologies implemented pursuant to the bill more than cover the costs of implementation and administration through the use of specified contracting models.

ESTIMATED FISCAL IMPACT:

Increased State Expenditures - $3,750,000/One-Time
$750,000/Recurring

Increased Federal Expenditures - $3,750,000/One-Time
$750,000/Recurring

Assumptions:

- According to the Bureau of TennCare (the Bureau), a centralized database for all TennCare and CoverKids claims data does not exist. To comply with the verification and screening requirements, the Bureau will be required to construct database infrastructure.
- According to the Bureau, construction of infrastructure for a centralized database would result in a one-time increase in state expenditures of $7,500,000 which includes $3,000,000 for hardware and software licensing and $4,500,000 for application design and development. Of this amount, $3,750,000 will be state funds at a rate of 50 percent and $3,750,000 will be federal funds at a 50 percent match rate.
- There will be a recurring increase in expenditures of $1,500,000 for annual operations costs. Of this amount, $750,000 will be state funds at a rate of 50 percent and $750,000 will be federal funds at a 50 percent match rate.

- According to the Bureau, the program currently contracts with a Recovery Audit Contractor (RAC) for after payment review that is paid on a 12 percent contingency fee contract for recoveries. Historically, CMS has limited the amount of recovery on contingency fee contracts. The current RAC contract limit is based on Medicare's maximum contract rates of 12.5 percent for all claims except durable medical equipment which has recently been increased to 17.5 percent.
- According to the Bureau, participating managed care organizations (MCOs) currently utilize prospective audits of claims and the savings realized by the state are built into the MCO capitation rates.
- Based on CMS's stance and the current RAC contracted contingency rate, the Bureau estimates that the expenditures incurred through construction and maintenance of a database to duplicate current activities would not be offset by additional savings.

CERTIFICATION:

The information contained herein is true and correct to the best of my knowledge.

Lucian D. Geise, Executive Director

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